BAY AREA
HEALTH LIBERATION NEWS

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medical committee for human rights
Bay Area chapter
p.o. box 7677
san francisco, ca. 94119

METHADONE — LEGAL DOPE

The first fact to understand about Methadone is that it is a synthetic opiate, and is as addicting as heroin or morphine, etc.

Any discussion about the politics and health aspects of Methadone Maintenance should begin with a brief history and overview of the drug abuse scene in America. Before 1914, the year the Harrison Narcotic Act was passed, addiction to opiates was common and legal and were easily gotten thru your doctor or sold over the counter thru magic elixers and patent medicines. It is reported that the ratio of addicts female to male was 3 to 2 and a majority were white middle-class. In his autobiography, Bill Haywood reports that mine workers in New Mexico in the 1890's were addicted to opiates sold to them by the mine's company store, thus insuring a constant source of controlled, addicted workers. Since 1914, when, in effect, heroin was banned, illegal production and distribution of heroin has been run by organized crime. With this shift from legal to illegal capitalism, the pattern of who became addicted greatly shifted. We thus find that in the period of 1945 to 1967 the ratio of whites to blacks has shifted from 3 to 1 to almost 1 to 2. We also find that since buying enough opiates each day to satisfy the habit is quite expensive, a new form of economic crime has been created—stealing money to buy drugs. In the past few years, 2 new factors have been added to this nightmare. First, there has been an explosive increase in the amount of heroin available and where you can get it. The other factor has been the reaction of a drug youth culture predominately based in the white middle- and upper-class. As many of these white kids started drug use and became abusers, their parents became hysterical and a massive bellow arose from the suburbs—"stop my kids from using drugs." The irony of this hypocritical outrage is saddening for two reasons because statistics clearly show that most major forms of drug abuse exist among adults (alcohol, cigarettes, barbituates, tranquilizers) and these adult abusers have been created by the legal dope pushers (drug, alcohol and cigarette companies). Secondly, when only black and brown kids were using addictive drugs, one never heard any noise or concern from the comfortable white suburbs.

POLITICAL FOOTBALL

This middle-class outrage has provided reactionary and liberal politicians with a wonderful set of issues; drugs, crime in the streets and law and order, and many have been elected or re-elected because of these issues, notably Rocky and Lindsay. But the reality has been that drug abuse has been among adults or youth, and drug-related economic crime has not lessened.

WHY PEOPLE ABUSE DRUGS

It must be emphasized that goverment—the C.I.A. and military and Federal Narcotic Agents —and "legal" and "illegal" businessmen are responsible for the vast availability of drugs. There is evidence that the major reasons people use and abuse these drugs are as follows: 1) oppression—liberal social scientists usually say that many people are alienated from the society but these Ph.D.'s cannot figure out why. The answer lies in the oppressive conditions that many people are forced to live under in this country. It is this condition of social oppression (which includes racism, class discrimination, sexism, poverty, plastic quality of life for middle-class kids, etc.) combined with the easy access to drugs that has always created large numbers of drug abusers. And one should be clear that social control of people thru the use of drugs is just as dangerous, or more so, as direct police state control. 2.) social conditioning—mass media, which pushes pills as the solution to all problems, has created a climate in which almost everybody is taking or abusing some drug.

RATIONALE FOR METHADONE

With all the above as background, the bandwagon for Methadone Maintenance programs has been created in the last six years to "get the addict off the street and into a productive life." This is the idealistic high-minded rationale for planning the deliberate addiction of potentially hundreds of thousands of heroin abusers. The other rationales for the use of Methadone Maintenance are as follows:

A. Metabolic Hunger theory of Dole and Nyswander—these two concerned medical scientists have strongly suggested that heroin abuse creates in the heroin addict a lifelong biochemical defect that requires lifelong chemical treatment with an opiate drug—and the drug is called Methadone. There is no good medical evidence to support this gobbledygook, but there is some evidence to disprove it. The Synanon community numbering in the 3,000 to 4,000, are people who were once addicted to heroin and now are no longer abusing drugs. (Synanon itself combines a collective lifestyle with a politically reactionary approach to drug abuses and thus is a caricature of U.S. society's contradictions.) In China, following the success of the liberation struggle, the Chinese Communist Government helped rehabilitate millions of people addicted to opiates. Today in China, people no longer abuse opiates.

B. Humanitarian Approach—by supplying a person with cheap legal methadone, the addict will feel better and will not have to go out and buy a fix of heroin. In other words, if we give people who have heroin habits methadone, we can keep them legally and cheaply addicted with the result that the methadone addict will not go out and steal money to buy heroin—thus crime in the streets is reduced. (A later article will show that this is the major reason for the growth of Methadone Maintenance.)

C. There is no high with Methadone.—The pushers of legal Methadone Maintenance say that the person will not get a pleasant high from Methadone. What they do not say is that if you shoot up Methadone in your vein, you do get a similar high to heroin; and even taken orally (which is the way it is given in Methadone Maintenance) many people experience a euphoria or high.

POLITICS OF METHADONE

There is a political rationale for Methadone Maintenance and this new drug movement carries political dangers. Liberal solutions are no solutions when you have a society (U.S.A.) in which the majority of people are addicted or abusing one or more drugs; and when the best solution you can offer to one small group of these drug abusers is to legalize their abuse, you have not offered a solution. As suggested above, the problem of heroin abuse is a symptom and outgrowth of complex political, economic, social, cultural and psychological factors, that are all directly traceable to one cause, which is the capitalist system we are forced to suffer and survive under. Liberals (and reactionaries) cynically accept the capitalist way of life and are

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INDIAN CLINIC

The Urban Indian Health Board was organized two and a half years ago due to the health needs of the Native Americans in the cities. The misconception that all Indians are entitled to health care through the Bureau of Indian Affairs has eliminated health care to American Indians in urban areas due to cultural barriers and low employment rates. The high cost of medical care has also been another cause for inadequate health care. The Indian population consists of aproximately 30,000 people within the Bay Area. Therefore; our Urban Indian Health Board presently covers the nine Bay Area counties. At present, we are fulfilling the Planning Grant by collecting data to assess our health needs and also provide a referral service. We have been funded recently for a Family Planning Project; however, this project does not offer service to all patients, so with the aid of a professional volunteer staff our immediate goal is to develop a health clinic which will qualify us to operate a no-fee, medical-dental clinic.

This is an all Indian program supported by a fifteen-member board with members associated with and knowledgeable in some phase of medical fields. There is also a fifteen-member advisory board to the Urban Indian Health Board.

We believe that each ethnic group has its own unique status and sense of self-determination, especially the American Indian. The physical geographic, financial, and cultural isolation are all problems which work against the Indians in California obtaining needed health care; and the delay in seeking or obtaining preventative care and early treatment of ills often results in secondary conditions and in acute and prolonged illnesses with more likelihood of fatality or permanent handicap.

The Regional Medical Center would include the following programs:

1. A complete hospital facility
2. A health professions training center
3. A research institute
4. A resource development center
5. A detoxication center
6. Traditional Indian Medicine

Anyone interested in our program is welcome to visit our clinic at:

56 Julian Avenue, San Francisco (863-8111)
(parallel to Mission at 14th)

Please call Urban Indian Health Clinic . . . The Executive Director is Miss Belva Cottier and the Associate Director is Mr. Ed Grijalva.

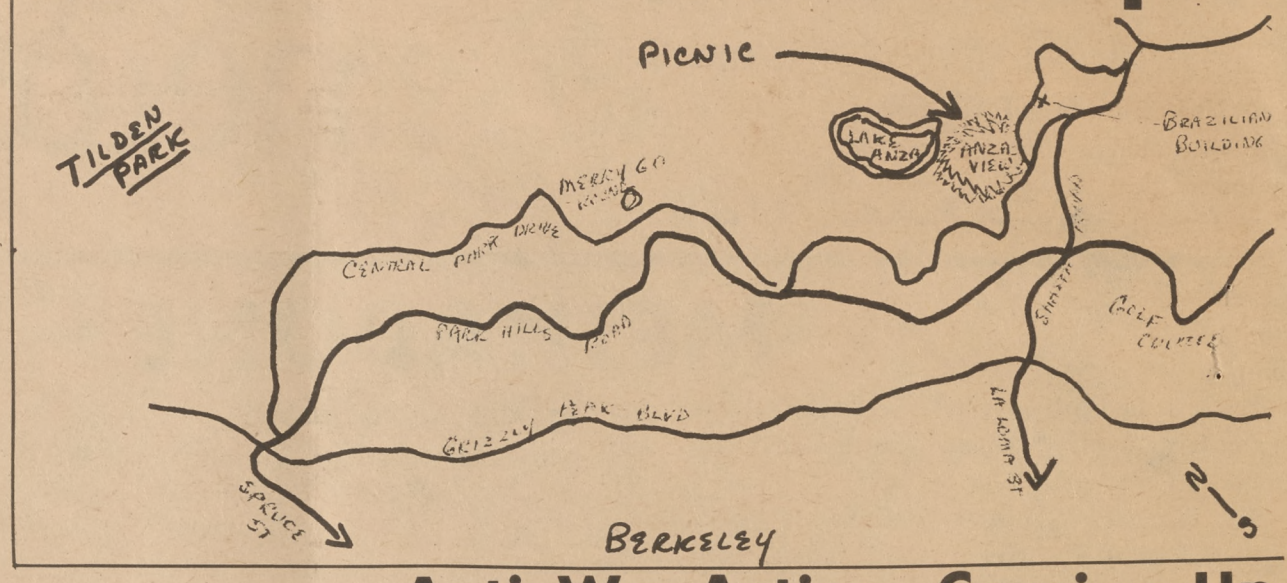
We are still seeking professional volunteers; medical, dental, drug, etc., services and any other donations which would help us provide the needed health care.

The Clinic will open August 5, 1972. In conjunction with the opening we will show Indian artifacts, cultural modes, Indian food, etc.

We greatly welcome your participation and attendance in making this event as exciting and effective as possible. . . . See you there!

MCHR Picnic! Sun. Aug 20 11am to 4pm

Last summer almost 100 people came to Tilden Park for a day of fun and meeting other MCHR members from the Bay Area—and we're doing it again this year. Follow the map below to the location reserved for us in Tilden Park, Berkeley. Bring your children, food, drink, frisbees, etc.



Anti-War Actions Coming Up

Four years ago, Nixon promised that Vietnam would not be an issue in this election campaign. His strategy is to cover up his expansion of the war and to force the Vietnamese to accept his settlement before the election through a combination of heavy bombings and threats of what it will be like if (when) he wins a second term.

Many people feel that McGovern is the answer. And it is true that he has promised to withdraw troops within 90 days of his election and end U.S. support for the corrupt Thieu regime in South Vietnam. (This promise incorporates the two main points of the P.R.G. 7-Point Peace Proposal.) However, he may not get elected and if he does win, the anti-war movement—largely responsible for his nomination—must continue to function independently to ensure his commitment throughout the campaign to the fulfillment of his promise.

Coalition Aims

Last April a new coalition of organizations in the Bay Area, including MCHR, sponsored the April 22 demonstration at Kezar Stadium. The April 22 Coalition was organized around three principles: (1) Support of the Provisional Revolutionary Government of South Vietnam's 7-Point Peace Proposal; (2) an end to U.S. interference in the affairs of other nations; (3) an end to Nixon's policies of economic, racial, sexual and political repression at home.

At our last annual convention the end of April, MCHR endorsed these themes as the principles for all chapters to organize around, stressing that efforts toward ending the war must have a high priority for all of us.

In a recent series of meetings, the April 22 Coalition has settled upon the following strategy for the summer and fall: to confront Nixon wherever he or his supporters come to campaign, making it difficult for him to win support in the Bay Area, and to keep the war on the front pages as the major issue of our time.

To accomplish these goals, the Coalition has planned a series of actions for the summer and fall:

1. The first will be a demonstration in downtown San Francisco while the Republican Convention is in session, going from Nixon headquarters to the Saigon Consulate. These targets will be used to underscore the complicity of the Nixon administration and the Thieu regime in the continuation of the war and to focus on the incredible repression in South Vietnam in the wake of NLF victories. The exact date for this demonstration has not been set yet.
2. On October 9 Nixon is scheduled to be in Fremont to participate in the opening ceremonies of BART. We will demonstrate there to protest his appearance in our state and use that opportunity to talk about Nixon's repressive domestic policies: the wage-price freeze, welfare cutbacks, his anti-people health plan, etc.
3. Finally, to make sure the war does not get shoved aside in the final days of the campaign, there will be an action at a major war target (like the Alameda Naval Air Station or the Oakland Army Terminal) during the week before the election.

Wanted—Volunteers

A lot of work needs to be done on these demonstrations. Plans have to be clarified and details worked out. A tremendous amount of leaflets, posters, etc. has to get out. The MCHR office needs a list of people in different institutions around the Bay who will be responsible for getting out the publicity. And, because we're a health organization, MCHR will be responsible for providing medical care at all the actions. People are also needed to work on the Coalition subcommittees for the various actions. MCHR has the "Automated Air War" slide show and the "Health War" film for use by local groups in hospitals or communities—just call the office (824-5888). Finally, volunteer medics, nurses and doctors are needed to provide medical coverage for the demonstrations. To volunteer for medical presence, and to get publicity out in your institution, call our office.

Correction!! Last month's issue ran our office address as 588 Capp St. This is wrong. Here's the correct information:

Medical Committee for Human Rights

Mailing address: P. O. Box 7677
San Francisco 94119

Office located at: 558 Capp St., San Francisco
(between Mission and S. Van Ness, and 20th and 21st Sts.)

Telephone: 824-5888

MCHR Meeting Refects Org. Problems

The new National Executive Committee of MCHR gathered together June 16th-18th and began by trying to assess its own role and responsibilities within the organization. It is apparent that the rapid growth of MCHR has created some problems. Most of the NEC reps would like to see the organization maintain its concentration on dealing politically with local problems in the present health care system. Yet MCHR should be able to present a national voice among radical health oriented people that would tie some of these local efforts together.

Two years ago, a national office was set up, an elected steering committee formed, and staff for a national office hired to help coordinate and give a broader focus for local projects. Many, many new members joined, new chapters were formed; and the national office was invaluable in setting up the books, arranging national conventions, putting out Health Rights News for membership, and answering inquiries about MCHR.

However, many members of MCHR have begun to worry that greater size could lead to an alienating and overly bureaucratic organization. There is concern that the national functions of the organization should always be accountable to the many local units that are the real body and soul of MCHR. The previous NEC began to work on those problems and the new NEC is continuing in that vein. Through all the discussions about the budget, task forces, the China trip, and functions of Health Rights News ran the same questions. What are the relationships between the different structures within MCHR and how can we maintain a democratic, open, and non-bureaucratic organization despite our growing size? To what degree should MCHR concentrate its limited resources and energy in the national office and to what degree should the national office serve the needs of local organizing efforts? What should be our priorities in the next year and what structures can we set up at the national level to facilitate them? What should be our approach to reaching out to new people? Do we want large numbers of interested people reached through mass media campaigns? Or do we instead want to concentrate on strengthening local chapters through study groups and local organizing efforts that would attract a smaller number of much more actively participating members?

ORGANIZATION:

The past year has seen a struggle by regions, the women's caucus, and third world caucus to obtain adequate representation on the NEC. The result has been a new NEC with equal participation of women and men, well distributed between the various regions, and with third world (minority groups and poor people) representation from each region. The new NEC reps are very closely tied with local chapters and this was reflected in their concern for using national organization to help build local chapters where possible.

In an effort to understand the focus of duties and powers within MCHR, the organizational structure was discussed. The NEC must report back to the national convention which forms the general policy and directions for the coming year. Reps are also responsible to represent the needs and ideas flowing from members of chapters in the regions they represent. Chapter and regional meetings are a natural forum for this

input. The national staff, in turn, should receive their direction from the NEC. Many felt that the staff had not been properly accountable to the NEC in the past year. The staff complained that the NEC had not given the support and direction that they needed to carry on day-to-day activities. A steering committee to communicate regularly with the staff was set up. People hoped that this would keep decision-making power in the organization continually in the hands of local regions, yet allowing the national office the degree of freedom to operate that they need in order to be effective.

BUDGET

A proposed budget for the following year was adopted. For the first time, "seed" money was set aside for local chapters, regions, and task forces. This will allow some chapters to hire desperately needed staff or have some funds to use in whatever ways necessary to help them with their work.

PRIORITIES:

Questions were raised about task forces. Their initial purpose was for communication between those doing similar projects across the country. Concern was voiced, however, that the setting up of countless task forces provided little opportunity for any overall assessment of which areas MCHR should spend more of its resources and energies on. There was not enough time for adequate discussion of the present task forces, and which should have priority. To deal with this and other uncompleted business, the next NEC meeting was scheduled for Sept. 1-4. A semi-annual convention was also scheduled—in Houston, Nov. 10-12, to deal with Women and the Third World.

Copies of the minutes are available at the office. More information about the upcoming convention will be published in following newsletters.

LAST MINUTE FLASH!
Stephanie Kline was scheduled to go to trial this morning (Aug. lst) but her trial was postponed till August 8th-- 9am at the Alemeda County Courthouse, Oakland.

HEALTH— WOMEN'S WORK

Womanpower is the manpower of the health field: 75 percent of all health workers are women. Control over this work force is crucial to those who control the health system.

The labor force within the health system is changing rapidly. There has been a vast increase in the number of health workers, from 2.9 million in 1960 to 3.9 million by 1969 to a projected 6.85 million by 1980. The roles they play are also changing: at the turn of the century, 80 percent of all health workers were doctors; today only 12 percent are doctors. New occupational divisions have developed to the point where there are now over 375 independent occupations. With their numerical supremacy, women health workers are a powerful potential power for change.

WOMANPOWER

The predominance of women in the health system developed historically because of two factors. Most jobs in health are dead end, low wage, semi-skilled or unskilled. This kind of work has traditionally gone to women, especially third world women. Also, health care jobs, with the exception of doctors and administrators, reflect the institutionalization of traditional women's functions: nurturing, caring, cooking, educating, cleaning. In the health system these functions become the jobs of nurse, housekeeper, dietician, clerk, social worker and technician.

Women are 98 percent of registered nurses, 64 percent of cooks, 74 percent of aides and attendants, 96 percent of practical nurses, 94 percent of nutritionists and dieticians, 95 percent of office workers, 80 percent of physical therapists, 75 percent of X-ray technicians, 90 percent of medical technologists and 89 percent of medical social workers. Almost all dental hygienists, medical librarians and clerks are women.

While women fulfill the "feminine functions" men make the decisions. Men are 93 percent of doctors, 90 percent of chiropractors, 98 percent of dentists, and 80 percent of hospital administrators. There is even a feminine role for woman doctors. The phrase "a woman's place is in the home" has been changed to "a woman's place is in pediatrics or child psychiatry," according to one woman doctor.

Wage differentials for the same job follow sex lines. In almost every field, especially where women overwhelmingly predominate, the wage difference is great. Thus the 145,942 women practical nurses receive on the average ten dollars less per week than their 3,350 male counterparts. Men's and women's salaries were equal in only one field: medical technology. Women health workers on the top suffer as well. Women doctors tend to take salaried institutional positions rather than go into higher paying private practice. And they can also expect less advancement.

—Reprinted from HEALTH/PAC BULLETIN, April 1972

Come to the MCHR picnic!

Win or Lose, Kaiser Strike Settled

Office workers in the Oakland Kaiser center, under contract with Local 29, Office & Professional Employees went on strike the beginning of July when contract negotiations bogged down over job security and retirement benefits.

Clerical layoffs and job terminations have been increasing as a result of Kaiser subcontracting office work with nonunion agencies. So one of the key union demands was for the protection of workers' jobs, with an end to the business of farming out their work to scab labor. The other demand at issue centered around the pension plan. Kaiser has its own plan which provides considerably less benefits to retired workers than Local 29's plan does. Employer contributions are identical for both plans. But the fly in the ointment is control over pension fund investments and the profits therefrom.

During thy 9-day strike, which was supported by the Teamsters' union, Local 250 Hospital Workers, ASCME and an AFT local, fifty or more trucks driven by management, under police escort, crossed the picket lines. Four picketers were arrested for trying to stop them.

THE SETTLEMENT

The strike was settled on a Sunday, July 9, with only 427 members, out of 900 covered workers, showing up to vote. Many members, not expecting settlement that quickly—and certainly not on a Sunday—were away for the weekend and not able to respond to the call. The settlement compromised job security with an oddball provision that management must consider with the union what would be the effect of subcontracting on employees whose jobs would be eliminated, and the effect on the delivery of health care. The latter stipulation is meant to suggest some limits on the work of the Health Plan office that gets done by an outside agency, whose workers would have no familiarity with the content of the health plan. On the pension plan, Kaiser refused to budge, holding onto its plan and profits at the expense of retired workers. But union officers recommended a "yes" vote and, with less than half the unit members voting, got it 312-115.

OTHER CONTRACT TERMS

Other provisions of the new contract swung the vote despite the loss on the crucial issues. There are pay increases (with the second year's hitched to Pay Board approval), an additional holiday a year, 5 weeks vacation after 15 years, boosts in nightwork differential and the part-time hourly rate (but casual workers get no other benefits). Improvements in fringe benefits include: psychiatric care for workers and their dependents; an optical plan starting with the second year of employment; sick pay during maternity leave; women's benefits under the dental plan equalized with those for men, where formerly there was discrimination against women's teeth.

It's a two-year contract, instead of one-year as in the past. To stop the firings that have been going on among Kaiser office workers, union members will have to keep close tabs on their officers over the next two years—to make sure they fight any threat to jobs.

Speakers on China

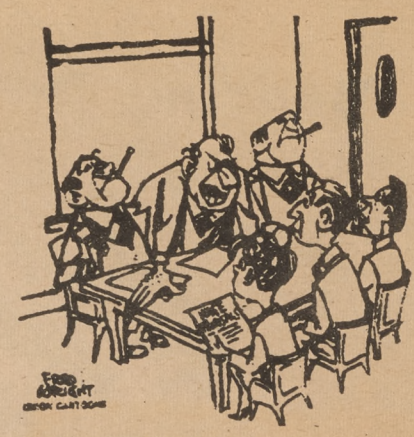
Sixteen members of MCHR from chapters all over the country just returned from a 3-week trip in China. While there they saw many aspects of the Chinese medical system, including psychiatric care, acupuncture operations, urban and rural clinics, care of deaf mutes and other examples of the striking steps in the care of its people that China has made under socialism. Fran Shapiro, Rn., and Phil Shapiro, Md., went on the trip from the Bay Area Chapter of MCHR. They took hundreds of pictures for slide show presentations and are available for speaking engagements. If you would like to arrange for one or both of them to come to your hospital, class or community group meeting, please call our office and leave a message for them. The number is 824-5888.

methadone con't

happy to make little changes or reforms that make them (the liberals) feel good, but in reality change little. Specifically, if you offer somebody a lifetime of methadone addiction in place of heroin addiction, you are really saying you don't believe people can change and you are telling the victim of drug oppression that he or she is not worth worrying about.

This truth can be verified by looking at the system's non-solution to 10,000,000 alcoholics, the racism directed at people of color, the oppression of working people, to such murderous limits as the recent mine disaster in Idaho and the dam breaking in West Virginia. And this truth should not surprise us! Because in a country like ours *the government* will be quite willing to tolerate 1/2 Million legal methadone addicts. The reason for this is quite clear. In history, there has never been a country with a social system based on profits and exploitation that has been able or willing to end drug abuse.

by Donald Goldmacher



"We are not listening to your demands until you agree to accept what we offer."

MEDICAL WORKER NEEDS HELP

Stephanie Kline's trial begins August 8th at Oaklnad Superior Court.

Stephanie, who works at El Centro de Salud in San Francisco's Mission District and belongs to MCHR, is charged with possession of explosives. These charges stem from an explosion in her car last January in which Tommy Davenport, a young black man, died. Stephanie was at home at the time of the explosion. If convicted, she faces a sentence of five years to life.

For leaflets, buttons, posters, come by 558 Capp Street or call 824-5888 (yes, we share MCHR's phone!). Please send donations.

Come to the trial. Oakland Superior Court is at 10th and Fallon. Take the Jackson Street exit off route 17.

Stephanie Kline Defense Committee

MCHR MEMBERSHIP

Please clip and return to MCHR, P.O. Box 7677, S.F. CA 94119

Name _____

Address _____

City _____ State _____

Zip _____ Phone _____

Job _____ Where? _____

☐ I would like to join MCHR. Enclosed are dues of $_____.

☐ I am making a contribution of $ to MCHR.

☐ I pledge $_____ each month to MCHR, beginning _____

FAIR SHARE DUES SCHEDULE
(please check proper box)

INCOME	% OF INCOME	CONTRIBUTION
up to $5,000	.1%	$8 ____
up to $10,000	.2%	$10-20 ____
up to $15,000	.3%	$30-45 ____
up to $20,000	.4%	$60-80 ____
above $20,000	.5%	$100 up ____

☐ I would only like to subscribe to Health Liberation News. Here's $3.

☐ I would only like to subscribe to Health Rights News. Here's $5.

☐ I would like more information on MCHR's _____ project.

Dues and contributions are tax-exempt.

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Bay Area Chapter
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